

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02673

2685

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Calvert</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Calvert</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Willows</b>		LENGTH OF STAY (in this place) <b>8 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Willows</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Rosanna Carton</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>March 14 1956</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>April 1, 1872</b>		<b>9. AGE last birthday</b> <b>83</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Dublin, Ireland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <input checked="" type="checkbox"/>	
<b>13. FATHER'S NAME</b> <b>Dennis McGuire</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Connelly</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Box 217 P. Thomas Carton, North Beach, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <b>Hypertensive C.V.R. disease</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>March 14, 1956</b> <b>to</b> <b>March 14, 1956</b> , <b>that I last saw the deceased alive on</b> <b>March 14, 1956</b> , <b>and that death occurred at</b> <b>3:14 P.M.</b> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <b>ADDRESS</b> (Street, city, town, state) <b>DATE SIGNED</b> <b>H. Weems</b> <b>Huntingtown</b> <b>3/14/56</b> M.D. <b>Huntingtown</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Mar. 16 / 56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Harmony</b>		<b>LOCATION</b> (City, town, or county) (State) <b>nr. Owings, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> DATE <b>Mar. 15, 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Grace L. Hutchins</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. D. Hutchins</b> ADDRESS <b>Owings, Md.</b>			

03073

# CERTIFICATE OF DEATH

1956

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

MAR 20 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. For this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2686

## CERTIFICATE OF DEATH

02674

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Calvert</b>		STATE <b>Maryland</b>		COUNTY <b>Calvert</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Owings</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Owings</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>MARTIN LUTHER CATTERTON</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Mar. 17 19 56</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>July 23, 1910</b>		<b>9. AGE last birthday</b> <b>45</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Oden Catterton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Georgianna Cox</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) _ _ _		<b>16. SOCIAL SECURITY NO.</b> <b>218-12-9016</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. George Catterton, Owings, Md.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>15. MEDICAL CERTIFICATION</b>	
<b>159K IMMEDIATE CAUSE (A)</b> <i>Carcinoma of G. I. tract exact location of origin undetermined</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>August 1953</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Exhaustion of origin undetermined</i>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Questionable Lupus Erythematosus</i>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>Aug</i>, 1955, to <i>March 17</i>, 1956, that I last saw the deceased alive on <i>March 17</i>, 1956, and that death occurred at <i>Aug</i>, M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>George D. Dett</i>				<b>DATE SIGNED</b> <i>3/18/56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>				<b>24. REC'D BY REGISTRAR</b> <i>Grace L. Hutchins</i>			
<b>DATE</b> <i>3/19/56</i>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. H. Hutchins</i>			

# CERTIFICATE OF DEATH

1956

BUREAU V. S.

MAR 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give name of decedent, date of death, and place of death. Pages 1, 2, and 3 should be executed by the funeral director. Page 4 should be executed by the Chief Medical Examiner's Office along with form PM-3. Pages 5 and 6 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 7 and 8 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnston</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnston</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Zang</u> First <u>Cole</u> Middle <u>Cole</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/56</u>
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Min. <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick Cole</u>		14. MOTHER'S MAIDEN NAME <u>Maynard Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>772.0</u>	
17. INFORMANT <u>Maynard Harris</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO <u>Poor Care</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Was delirious in H. Discharged in good condition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unmarried parents with poor care</u>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>P. E. Sewell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/22</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-23-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u>		22d. LOCATION (City, town, or county) (State) <u>Barnston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Dr. Fred, Md.</u>	
24a. REC'D BY REGISTRAR <u>2-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

2064286906





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02676

2688 **CERTIFICATE OF DEATH**

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Calvert</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Calvert</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Prince Frederick</b>		LENGTH OF STAY (In this place) <b>7 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Huntingtown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Calvert County Hospital</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>CORA WILSON CRANFORD</b>				<b>4. DATE OF DEATH</b> (Month) <b>March</b> (Day) <b>5</b> (Year) <b>1956</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>November 11, 1864</b>	<b>9. AGE last birthday</b> <b>91</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>same</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>David I. Bowen</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Elizabeth Ireland</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>---</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Julius O. Bowen, Huntingtown, Md.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>Coronary occlusion</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>generalized arterio-sclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>2-29-56</u>, 19<u>56</u>, to <u>3-5</u>, 19<u>56</u>, that I last saw the deceased alive on <u>March 5, 1956</u>, and that death occurred at <u>5 p.</u> M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Rd Williams</i>				<b>DATE SIGNED</b> <u>3/6/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>March 7, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Huntingtown Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Mar. 6, 1956</b>				<b>REGISTRAR'S SIGNATURE</b> <i>Grace L. Hutchins</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wm. H. Hutchins</i>	
				<b>LOCATION (City, town, or county)</b> <b>Huntingtown, Md.</b>		<b>ADDRESS (Street, city, town, state)</b> <b>Wm. H. Hutchins, Owings, Maryland</b>	

15071

ANNOUNCED STATE DEPARTMENT OF HEALTH-BALTIMORE

# 2000 CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Date of registration: \_\_\_\_\_

BUREAU V. S.

MAR 12 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2689

CERTIFICATE OF DEATH

02677 51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>02x 2v</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oden</u> Middle <u>W.</u> Last <u>Elliott</u>				4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/22/1894</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>61</u> Days <u>18</u> Hours <u>19</u> Min. <u>56</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Joseph Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. BESSIE ELLIOTT</u> Address <u>Deale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Arteriosclerosis of heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Has been bedridden for several years</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> 19 <u>56</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>3/10/56</u> 19 <u>56</u> , to <u>3/18</u> 19 <u>56</u> , that I lost saw the deceased alive on <u>3/18</u> 19 <u>56</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Anderson</u> M.D.				ADDRESS (Street, city or town, state) <u>Deale, Md.</u>			
DATE SIGNED <u>3/20/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hoodfields</u>		22d. LOCATION (City, town, or county) (State) <u>Deale, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard C. Hardisty</u> ADDRESS <u>Shelburne</u>				24a. REC'D BY REGISTRAR <u>Dr. Hugh Hardisty</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 23 1956</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PORTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. 3

MAY 23 1956

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be submitted within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02679	
2690. MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 51	
1. PLACE OF DEATH a. COUNTY <u>Calvert</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>					c. LENGTH OF STAY IN 1b						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co</u>					d. STREET ADDRESS <u>CROVER</u>						
3. NAME OF DECEASED (Type or print) <u>Robert William Robert James Jr</u>					4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1956</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1945</u>		9. AGE (In years last birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>37</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>											
13. FATHER'S NAME <u>William Robert Grover</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Louise McCready</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u></u>					17. INFORMANT Name <u>Wesley McCready Tushy</u> Address <u>us</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Curled chest with hemorrhage</u> DUE TO <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u></u> (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was hit when he was going down #2</u>											
20a. EXTENSIONAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u>4:15</u> p.m. Month <u>3/9</u> Day <u>19</u> Year <u>56</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Boat</u>			20f. (City or town) <u>Solomons</u> (County) <u>Calvert</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
SIGNATURE <u>H W Ward</u>					DATE SIGNED <u>3/9/56</u>						
EXAMINER'S NAME (Type) <u>H W Ward</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Mar. 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>			22d. LOCATION (City, town, or county) <u>Lusby - Calvert Co - Md</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Yarkness &amp; Son - Mutual, Md.</u> ADDRESS <u></u>					24a. REC'D BY REGISTRAR <u></u> DATE <u>3-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>				

LIBRARY V. S.  
MAR 12 19

RECEIVED

2691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

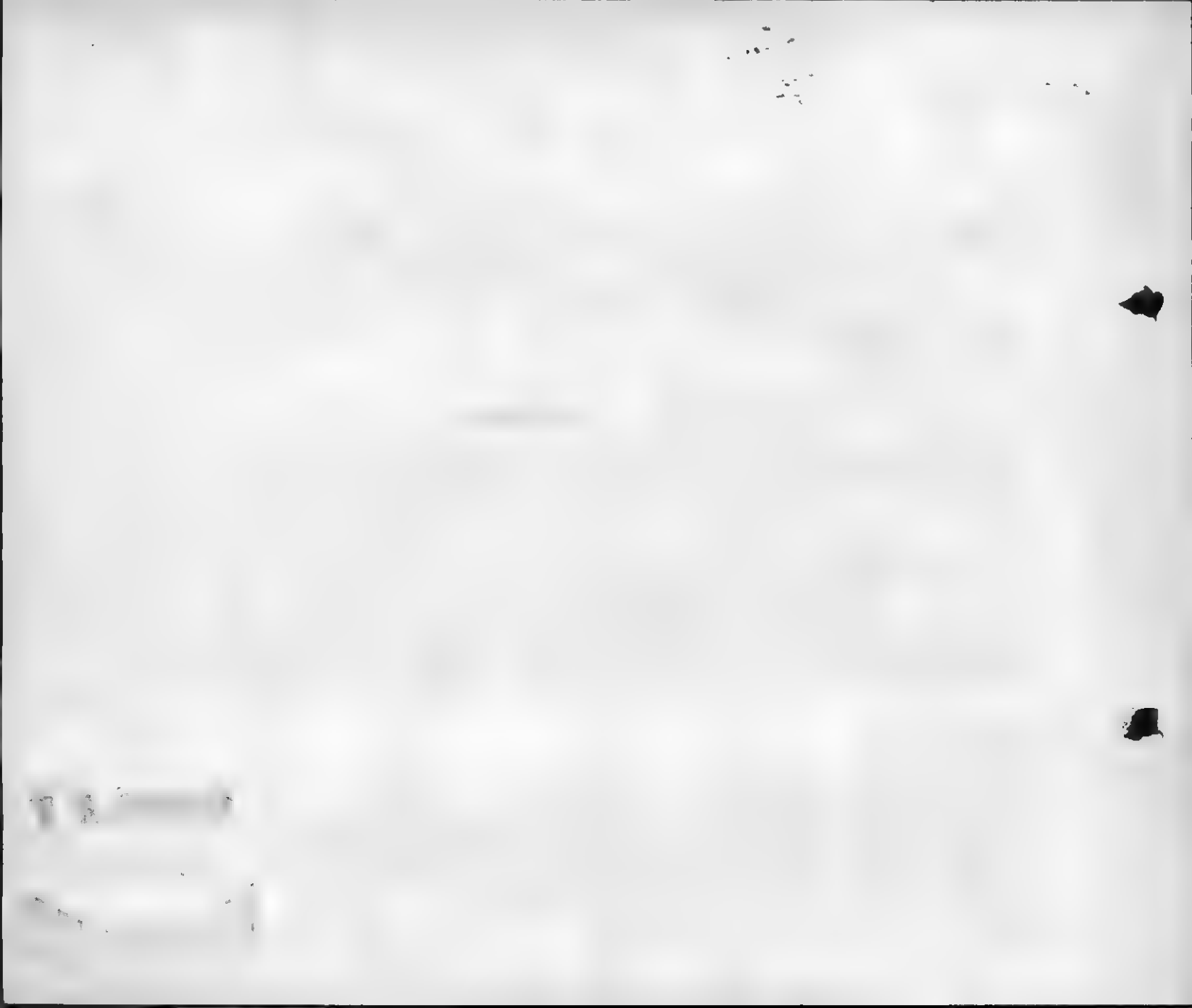
Item 2, File 335 4-6-56 et

Reg. Dist. No. 57

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u> c. LENGTH OF STAY IN 1b <u>Island Creek</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u> d. STREET ADDRESS		* IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Santh</u> Middle <u>James</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27 1879</u>	9. AGE (In years, top birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W</u>		11. BIRTHPLACE (State or foreign country) <u>W</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Thomas Santh</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mathe Santh</u> Address <u>Island Creek</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolism</u> <u>4x0.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Has been ailing for sometime 2 yrs</u> (c) <u>Cerebral</u> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDIT ON GIVEN IN PART I (a) <u>Was feely good, got up dressed, collapsed at 5:30 p.m. died at 10:30 p.m.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>at 10:30 p.m.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a. m. <u>30</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/27/56</u>	
EXAMINER'S NAME (Type) <u>H W Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-1-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Brook</u>	
				22d. LOCATION (City, town, or county) <u>Island Creek Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R E Sewell, Fred, Md</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3-28-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. A. Ward</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Reg. 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## 2692 CERTIFICATE OF DEATH

Reg. Dist. No. 51

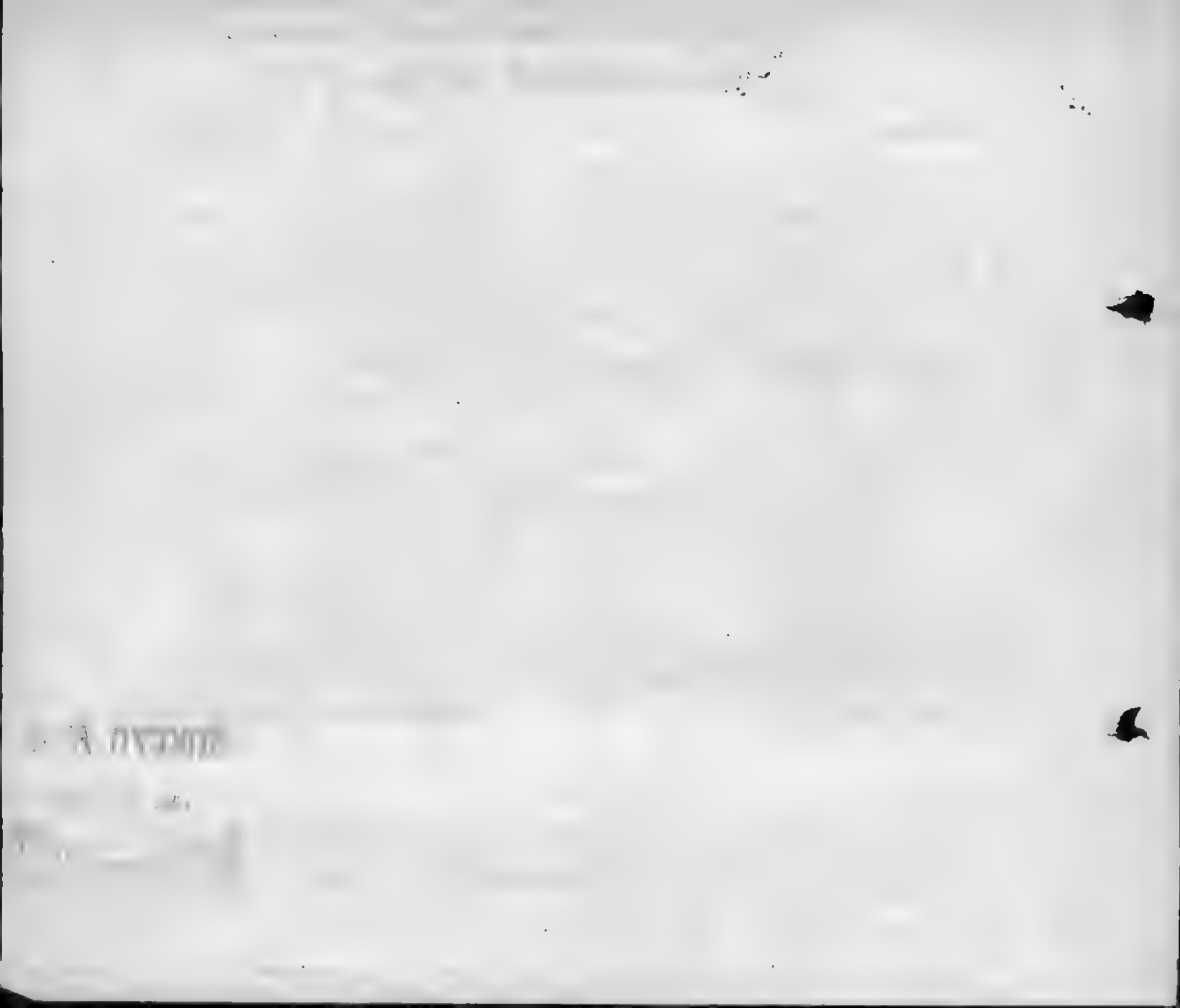
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Calvert</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		LENGTH OF STAY (In this place) <i>15 min.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake Beach, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Bell</i>				<i>Hubbard</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>3/31/1888</i>	
9. AGE last birthday <i>67</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Samuel Somers</i>				14. MOTHER'S MAIDEN NAME <i>Anna Moore</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>MR. Collie Hubbard</i> <i>Chesapeake Beach, Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Auricular Fibulation</i>						<i>five day.</i>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10 Feb</i> , 19 <i>53</i> , to <i>7 Mar</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>7 Mar</i> , 19 <i>56</i> , and that death occurred at <i>9:15</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>J. Hee</i>				ADDRESS (Street, city, town, state) <i>M.D. Huntingtown, Md.</i>			
DATE SIGNED <i>7 Mar 56</i>							
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Mar. 11</i>		NAME OF CEMETERY OR CREMATORY <i>Efford Md.</i>		LOCATION (City, town, or county) (State) <i>Efford Md.</i>	
24. REC'D BY REGISTRAR <i>3-7-56</i>		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Newnam</i>			
DATE		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



2693

## CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWENS</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowens</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bowens</u>			d. STREET ADDRESS <u>Bowens</u>		
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Victoria</u> Last <u>Hutchins</u>			4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 April, 1880</u>		9. AGE (In years last birthday) <u>75</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Bowens</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Thomas W. Hall</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Hutchins</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>John W. Hutchins Bowens, Ind.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure - Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>27 March 1955</u> to <u>15 March 1956</u> , that I last saw the deceased alive on <u>15 March 1956</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Thomas M. Hutchins</u>			ADDRESS (Street, city or town, state) <u>7315 Landover Rd Hyattsville, Ind 47040</u>		
PHYSICIAN'S NAME (Type) <u>THOMAS M. HUTCHINS</u>			DATE SIGNED <u>24 March 1956</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) <u>Barstow - Calvert Co - Ind.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. B. Hackman &amp; Son - Mutual, Ind</u>			24a. REC'D BY REGISTRAR <u>3-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9 2810

1000



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2694

## CERTIFICATE OF DEATH

Reg. Dist. No.

038250

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>L.</u> Last <u>Selby</u>				4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1873</u>	9. AGE (In years last birthday) <u>82 yrs</u>	IF UNDER 1 YEAR: Months <u>11</u> Days <u>24</u> Hours <u></u> Min <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Selby</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Culbertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-1081</u>		17. INFORMANT Name <u>W. Edward Selby</u> Address <u>Solomons, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> <u>152x</u> DUE TO <u>Carcinoma Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>✓</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>54</u> to <u>Mar</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Mar-25</u> 19 <u>56</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. S. Coster</u>				ADDRESS (Street, city or town, state) <u>Solomons, Md.</u> DATE SIGNED <u>3/28/56</u>			
PHYSICIAN'S NAME (Type) <u>E. S. COSTER</u>				ADDRESS <u>Solomons, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Solomons Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Thacker &amp; Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>3/28/56</u>		24b. REGISTRAR'S SIGNATURE <u>E. S. Coster</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1/4 1980

1/4 1980

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02683

Reg. Dist. No. 51

Item 9, Filed 3-19-56

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burderland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burderland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary C. Strauter</u> First Middle Last <b>5. SEX</b> <u>7</u> <b>6. COLOR OR RACE</b> <u>C</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct 1</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>66</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <u>3</u> <u>16</u> <u>1956</u> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H W</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Md</u> <b>11. BIRTHPLACE</b> (State or foreign country) <b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>James Strauter</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Jones</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Virginia Gray Sanderland Md</u> (If yes, give war or dates of service) Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolism</u> <u>4:20 P</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11/4</u> <u>3/16</u> <u>1956</u> Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>H W Ward</u> <b>EXAMINER'S NAME (Type)</b> <u>H. W. Ward, D.M.E.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>3/16/56</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>22b. DATE THEREOF</b> <u>3-19-56 <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Brooks</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>Island Creek Md</u> </u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <u>H. W. Ward</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1. 1st

3. *Phragmites australis* (Cav.) Trin. ex Steud.  
 Common reed, marsh grass.

22/10/2012

عبد الرحمن

3-18-25



02678

## 2696 CERTIFICATE OF DEATH

Reg. Dist. No. 51

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Calvert</i>
CITY (If out of corporate limits, write RURAL and give nearest town) TOWN <i>Barstow, Md.</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Barstow, Md.</i>	STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Edward</i>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>3-31-1956</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>(Widowed)</i>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>John Joye</i>		14. MOTHER'S MAIDEN NAME <i>Harriet White</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <i>Thornton Joye Prince Fred</i>	
<b>18. MEDICAL CERTIFICATION</b>			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Severe aortic sclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/30</i> , 19 <i>56</i> , to <i>3/31</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3/31</i> , 19 <i>56</i> , and that death occurred at <i>10:41</i> M., from the causes and on the date stated above.			
SIGNATURE <i>R. E. Sewell</i>		ADDRESS (Street, city, town, state) <i>St. James</i> DATE SIGNED <i>4/3</i>	
23. (BURIAL, CREMATION, REMOVAL) (SPECIFY)	DATE THEREOF <i>4-3-56</i>	NAME OF CEMETERY OR CREMATORY <i>Carroll</i>	LOCATION (City, town, or county) (State) <i>Barstow, Md.</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i> ADDRESS <i>Pr. Fred, Md.</i>	
DATE <i>4/3/56</i>			

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



RECEIVED

APR 4 1956

BUNDAU V. S.

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

02684

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Calvert</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Calvert</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Sunderland</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Sunderland</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>WILLIAM</b>		(Middle) <b>SAMUEL</b>		(Last) <b>TURNER</b>		(Month) <b>March</b> (Day) <b>15</b> (Year) <b>19 56</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>January 26, 1887</b>		<b>9. AGE last birthday</b> <b>69</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Owner</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Samuel Turner</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ida Virginia Marquess</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>217-36-7322</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Wm. Turner, Sunderland, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>430.1 IMMEDIATE CAUSE (A)</b> <b>CORONARY OCCLUSION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 1/2 hours</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <b>Due to Gastric ulcer</b>						<b>19.50</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Varicose veins of both legs</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Sept 15, 1954</u>, to <u>March 15, 1956</u>, that I last saw the deceased alive on <u>March 15, 1956</u>, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Grace L. Nutkin</i>				<b>ADDRESS (Street, city, town, state)</b> <i>Burice Federal</i>		<b>DATE SIGNED</b> <i>3/16/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Mar. 17 / 56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Harmony Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Owings, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>3/17/56</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Grace L. Nutkin</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. H. Nutkin</i>		<b>ADDRESS</b> <i>Owings Md</i>	

# CERTIFICATE OF DEATH

DATE OF DEATH

1. Name of deceased  
2. Sex  
3. Age  
4. Race  
5. Birth date  
6. Birth place  
7. Usual residence  
8. Cause of death  
9. Date of death  
10. Place of death  
11. Signature of physician  
12. Signature of registrar

13. Name of informant  
14. Relationship to deceased  
15. Signature of informant  
16. Date of statement

17. Name of informant  
18. Relationship to deceased  
19. Signature of informant  
20. Date of statement

21. Name of informant  
22. Relationship to deceased  
23. Signature of informant  
24. Date of statement

25. Name of informant  
26. Relationship to deceased  
27. Signature of informant  
28. Date of statement

29. Name of informant  
30. Relationship to deceased  
31. Signature of informant  
32. Date of statement

33. Name of informant  
34. Relationship to deceased  
35. Signature of informant  
36. Date of statement

37. Name of informant  
38. Relationship to deceased  
39. Signature of informant  
40. Date of statement

BUREAU V. S.

MAR 22 1956

RECEIVED

2698

## CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH a. COUNTY <u>Cabnet</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Cabnet</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Solomons</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20</u>		d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Elizabeth Webster</u>			4. DATE OF DEATH Month Day Year <u>Mar. 11, 1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1873</u>		9. AGE (In years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John G. Saunders</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Vaughan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>H. B. Glescock - Solomons, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V. disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>5 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>March 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Prince Frederick</u> PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u> <u>PRINCE FREDERICK, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middleham Chapel</u>	
22d. LOCATION (City, town, or county) <u>Fusby - Cabnet Co. - Md.</u>		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Haskins &amp; Son - Mutual, Md.</u>		ADDRESS _____ 24a. REC'D BY REGISTRAR DATE <u>3-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

FILE NO. 101

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Date of death: _____</p>	
<p>5. Place of birth: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Signature of informant: _____</p>		<p>12. Signature of witness: _____</p>	
<p>13. Signature of funeral director: _____</p>		<p>14. Signature of undertaker: _____</p>	
<p>15. Signature of coroner: _____</p>		<p>16. Signature of justice: _____</p>	
<p>17. Signature of clerk: _____</p>		<p>18. Signature of recorder: _____</p>	
<p>19. Signature of auditor: _____</p>		<p>20. Signature of treasurer: _____</p>	
<p>21. Signature of controller: _____</p>		<p>22. Signature of comptroller: _____</p>	
<p>23. Signature of assessor: _____</p>		<p>24. Signature of collector: _____</p>	
<p>25. Signature of clerk: _____</p>		<p>26. Signature of recorder: _____</p>	
<p>27. Signature of auditor: _____</p>		<p>28. Signature of treasurer: _____</p>	
<p>29. Signature of controller: _____</p>		<p>30. Signature of comptroller: _____</p>	
<p>31. Signature of assessor: _____</p>		<p>32. Signature of collector: _____</p>	
<p>33. Signature of clerk: _____</p>		<p>34. Signature of recorder: _____</p>	
<p>35. Signature of auditor: _____</p>		<p>36. Signature of treasurer: _____</p>	
<p>37. Signature of controller: _____</p>		<p>38. Signature of comptroller: _____</p>	
<p>39. Signature of assessor: _____</p>		<p>40. Signature of collector: _____</p>	
<p>41. Signature of clerk: _____</p>		<p>42. Signature of recorder: _____</p>	
<p>43. Signature of auditor: _____</p>		<p>44. Signature of treasurer: _____</p>	
<p>45. Signature of controller: _____</p>		<p>46. Signature of comptroller: _____</p>	
<p>47. Signature of assessor: _____</p>		<p>48. Signature of collector: _____</p>	
<p>49. Signature of clerk: _____</p>		<p>50. Signature of recorder: _____</p>	
<p>51. Signature of auditor: _____</p>		<p>52. Signature of treasurer: _____</p>	
<p>53. Signature of controller: _____</p>		<p>54. Signature of comptroller: _____</p>	
<p>55. Signature of assessor: _____</p>		<p>56. Signature of collector: _____</p>	
<p>57. Signature of clerk: _____</p>		<p>58. Signature of recorder: _____</p>	
<p>59. Signature of auditor: _____</p>		<p>60. Signature of treasurer: _____</p>	
<p>61. Signature of controller: _____</p>		<p>62. Signature of comptroller: _____</p>	
<p>63. Signature of assessor: _____</p>		<p>64. Signature of collector: _____</p>	
<p>65. Signature of clerk: _____</p>		<p>66. Signature of recorder: _____</p>	
<p>67. Signature of auditor: _____</p>		<p>68. Signature of treasurer: _____</p>	
<p>69. Signature of controller: _____</p>		<p>70. Signature of comptroller: _____</p>	
<p>71. Signature of assessor: _____</p>		<p>72. Signature of collector: _____</p>	
<p>73. Signature of clerk: _____</p>		<p>74. Signature of recorder: _____</p>	
<p>75. Signature of auditor: _____</p>		<p>76. Signature of treasurer: _____</p>	
<p>77. Signature of controller: _____</p>		<p>78. Signature of comptroller: _____</p>	
<p>79. Signature of assessor: _____</p>		<p>80. Signature of collector: _____</p>	
<p>81. Signature of clerk: _____</p>		<p>82. Signature of recorder: _____</p>	
<p>83. Signature of auditor: _____</p>		<p>84. Signature of treasurer: _____</p>	
<p>85. Signature of controller: _____</p>		<p>86. Signature of comptroller: _____</p>	
<p>87. Signature of assessor: _____</p>		<p>88. Signature of collector: _____</p>	
<p>89. Signature of clerk: _____</p>		<p>90. Signature of recorder: _____</p>	
<p>91. Signature of auditor: _____</p>		<p>92. Signature of treasurer: _____</p>	
<p>93. Signature of controller: _____</p>		<p>94. Signature of comptroller: _____</p>	
<p>95. Signature of assessor: _____</p>		<p>96. Signature of collector: _____</p>	
<p>97. Signature of clerk: _____</p>		<p>98. Signature of recorder: _____</p>	
<p>99. Signature of auditor: _____</p>		<p>100. Signature of treasurer: _____</p>	

BUREAU V. S.

MAR 14 1956

RECEIVED